ATTENDING DENTIST'S STATEMENT
See Reverse Side For Claim Filing Instructions
CHECK ONE:
☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

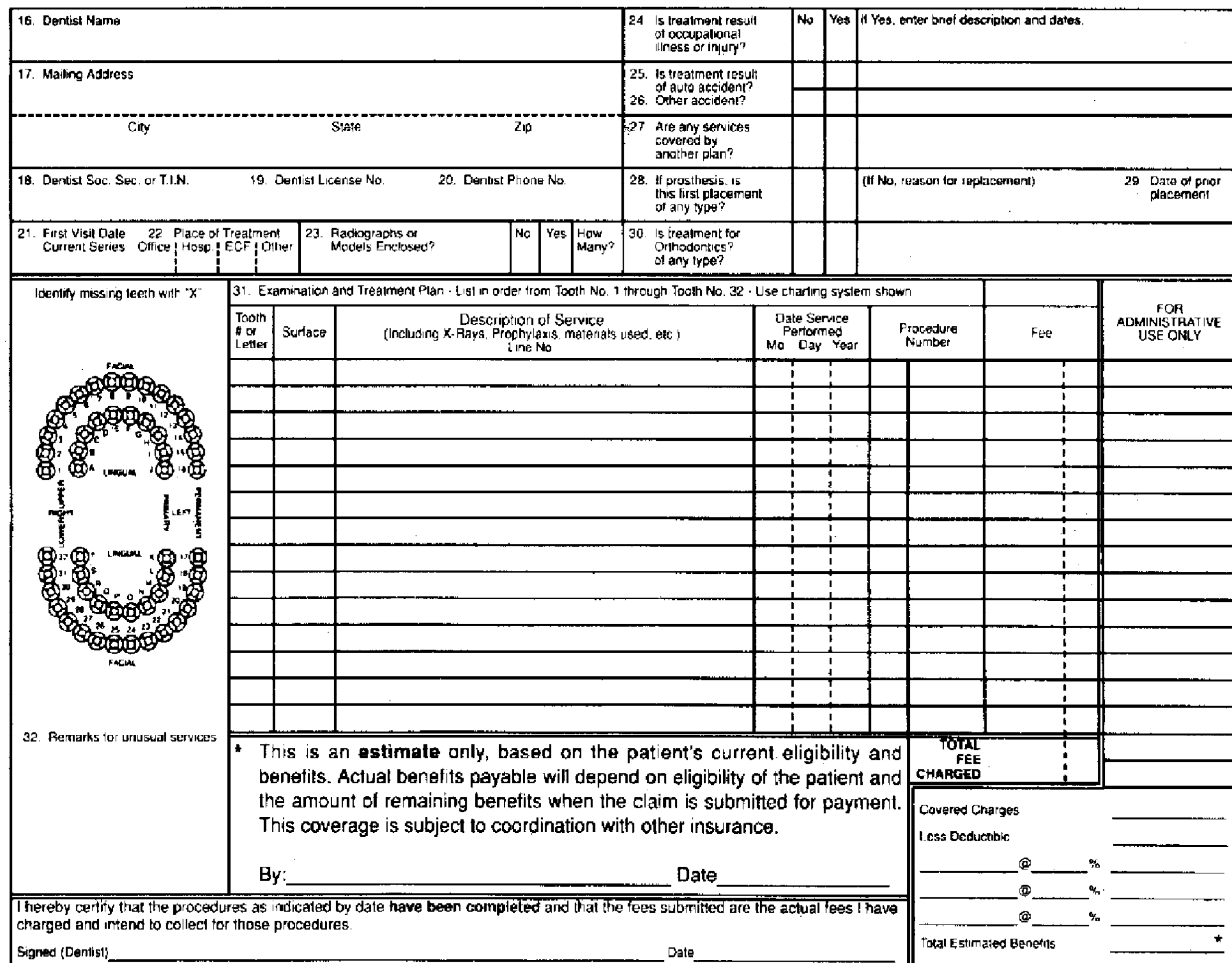
The Christian Brothers Employee Benefit Trust

1205 Windham Parkway
Romeoville, Illinois 60446-1694

Employee Statement

1. Patient Name	2. Relationship to Employee: Self / Spouse / Child / Other	3. Sex: M / F	4. Patient Birthdate: Mo. / Day / Year	5. If Full-Time Student: School / City
6. Employee Name: First / Middle / Last	7. Employee S.S. No.	9. Location Number		
8. Employee Mailing Address		10. Employer (Company) Name and Address		
City / State / Zip		City / State / Zip		
11. Is Employee: Single ☐ Married ☐ Divorced ☐ Widowed ☐	12. Spouse's Name and Birthdate: Mo. / Day / Year	13. Is spouse employed? Yes ☐ No ☐	14. If "Yes", give name, address, and telephone no. of spouse's employer	
15. Is Patient covered by another Plan of Benefits? **Dental** Yes ☐ No ☐ **Medical** Yes ☐ No ☐	If "Yes", give name of Person carrying the other coverage	Dental Plan Name	Group No.	Name and Address of Carrier
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. Signed (Patient or Parent if Minor) ______ Date ______		I hereby authorize payment directly to the below named dentist of the Dental Benefits otherwise payable to me. Signed (Employee) ______ Date ______		

Attending Dentist's Statement



16. Dentist Name	24. Is treatment result of occupational illness or injury?	No	Yes	If Yes, enter brief description and dates.
17. Mailing Address	25. Is treatment result of auto accident?			
	26. Other accident?			
City / State / Zip	27. Are any services covered by another plan?			
18. Dentist Soc. Sec. or T.I.N. / 19. Dentist License No. / 20. Dentist Phone No.	28. If prosthesis, is this first placement of any type?			(If No, reason for replacement) / 29. Date of prior placement
21. First Visit Date Current Series / 22. Place of Treatment: Office / Hosp. / ECF / Other / 23. Radiographs or Models Enclosed? No / Yes / How Many?	30. Is treatment for Orthodontics? of any type?			

Identify missing teeth with "X"

31. Examination and Treatment Plan - List in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown

Tooth # or Letter	Surface	Description of Service (Including X-Rays, Prophylaxis, materials used, etc.) Line No	Date Service Performed Mo Day Year	Procedure Number	Fee	FOR ADMINISTRATIVE USE ONLY

TOTAL FEE CHARGED

32. Remarks for unusual services

* This is an **estimate** only, based on the patient's current eligibility and benefits. Actual benefits payable will depend on eligibility of the patient and the amount of remaining benefits when the claim is submitted for payment. This coverage is subject to coordination with other insurance.

By: ______ Date ______

Covered Charges ______
Less Deductible ______
______ @ ______ % ______
______ @ ______ % ______
______ @ ______ % ______
Total Estimated Benefits ______ *

I hereby certify that the procedures as indicated by date **have been completed** and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Dentist) ______ Date ______

IFS 4336-14

Use This Form for Both Employee and Dependent Claims

The standard computerized dental form may be used in lieu of this form.

INSTRUCTIONS TO THE EMPLOYEE

1. Complete Questions 1 through 15 on the reverse side. Have Patient's Dentist complete Questions 16 through 31.
2. If charges exceed $200.00, a treatment plan must be submitted prior to continuation of treatment.

INSTRUCTIONS TO THE DENTIST

For Charges LESS THAN $200.00

1. Show the date the work was completed for each service and the corresponding fee.
2. Retain a copy for your files and forward the original to us.

For Charges EXCEEDING $200.00

1. Prior to the continuation of non-emergency treatment, describe procedures necessary to fully complete the treatment plan. State your fees, enclose x-rays (these will be returned to you) and return the form to **The Christian Brothers Employee Benefit Trust** (address below). Keep a copy for your records.
2. The amount payable per procedure will be predetermined and a copy of this form will then be returned to you.
3. After the work is completed, enter the dates that the service was completed and return this form to us. Retain a copy for your files.

NOTICE! The predetermined benefits apply only to expenses incurred while the employee's coverage is in force.

Please mail completed form to: **The Christian Brothers Employee Benefit Trust**
1205 Windham Parkway
Romeoville, Illinois 60446-1694
Phone: 630-378-2900 ■ Toll-Free: 800-807-0400